







Mental health training in family medicine residencies: International curriculum overview

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Abstract

Integration of mental health into primary care has become a global trend, and many countries have developed mental health training in primary care. However, systematic mental health training for family physicians is insufficient in Japan. The newly established Japan Primary Care Association Mental Health Committee surveyed the current status of mental health training curricula in family medicine residency internationally. Participants were individuals involved in family medicine residency programs who were from Australia, Brazil, Hong Kong, the Philippines, Taiwan, the United Kingdom, and the United States. The results revealed that many academic societies have created competency lists and curriculum guidelines for mental health training; however, the implementation varied. This study is novel as it examined and compared different countries' curriculum; the findings of which can be used as a reference to develop future mental health training curriculum in Japan.

KEYWORDS

curriculum, family medicine, mental health, residency, training

1 | INTRODUCTION

Recently, the number of patients requiring psychiatric care has increased, with about 4.19 million cases in Japan in 2017.¹ The number of physicians with psychiatry as their primary area of practice increased from 14,201 in 2010 to 16,490 in 2020, which was 5.1%

of the total number of physicians.^{2,3} However, patients may not be receiving adequate psychiatric treatment. In 2018, the number of psychiatrists in the Organisation for Economic Co-operation and Development (OECD) was 15.3 per 100,000, which was high in Europe (e.g., Germany: 27.2, France: 22.7, United Kingdom: 18.0) and low in Asia and Africa. Japan, which was one of the highest in

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Asia, had a rate of 11.9, which was lower than the OECD average.^{4,5} In the United Kingdom, primary care physicians treat 90% of psychiatric disorders;⁶ and in Japan, some note that primary care physicians see patients with mood and anxiety disorders equally or even more than psychiatrists.^{7,8}

Patients with mental health problems are at higher risk of chronic disease, use more medical resources, and are more likely to have decreased quality of life due to increased morbidity.^{9,10,11} There is an acute need for appropriate mental health care to be provided in primary care worldwide. However, there is a lack of mental health training among primary care providers.¹² There have been numerous studies worldwide on mental health training for primary care providers, including family physicians.^{13,14} Professional associations of family physicians, such as the World Organization of Family Doctors (WONCA),¹⁵ the American Academy of Family Physicians (AAFP),¹⁶ and the Royal College of General Practitioners (RCGP),¹⁷ have also proposed recommendations for mental health training in their specialty residency.

The Japan Primary Care Association (JPCA) has set the following objectives for mental health training in family medicine residency programs in Japan: clinical experience in symptomatic psychosis, dementia, addiction, depression, bipolar disorder, schizophrenia, anxiety disorders, somatoform disorders, adjustment disorders, insomnia, perinatal mental health, and developmental disorders.¹⁸ Additionally, portfolios, Objective Structured Clinical Examinations (OSCEs), and written exams on mental health are required as a part of the board certification exam. However, mental health training is not mandatory for residents, and the JPCA has not developed adequate and systematic training for mental health in primary care. The 2019 WONCA report for the international accreditation of Japan's family medicine residency programs recommended the enhancement of mental health training.¹⁹

For this reason, the JPCA established a Mental Health Committee in 2020. It works to improve the quality of mental health care and training for members of JPCA, especially for its residents. Kawada et al.²⁰ conducted a scoping review of the competencies required in family medicine residency programs. However, they did not find adequate information in the literature to help them comprehensively understand what was offered, internationally, in mental health training programs. Existing literature was inadequate in scope of the study,^{14,21} target population,²² and types of training.^{23,24} For example, Leigh et al.^{14,21} surveyed the status of psychiatry training in family medicine and other specialties; however, the study only covered domestic programs in the US, not internationally. Tsutsumi et al.²² studied competencies in undergraduate medical education in Japan, not family medicine residents. Stensrud et al.²³ focused on training in communication skills, and Dove²⁴ focused on competencies in addiction disorders.

This survey was an exploratory descriptive study that is part of the committee's activities. We aimed to overview and compare the actual status of mental health training for family medicine residencies internationally. This type of overview has not been conducted to date. We expect the survey to be a useful source, leading to recommendations for new mental health training in Japan.

2 | METHODS

2.1 | Participants and data collection and analysis

We recruited participants for the survey via the WONCA Working Party for Mental Health and the WONCA Asia Pacific Region's mailing networks, and through referrals from committee members. The target population comprised personnel involved in family medicine residency programs overseas, such as program directors and attending physicians. Those who were only involved in medical school education, could not communicate in English, or could not participate in the follow-up questionnaire were excluded from the survey. The survey was conducted from April to September, 2021. The survey was semi-structured in design, beginning with an open-ended questionnaire via an online form. An online interview or e-mail communication followed with respondents detailing the questionnaire. The questionnaire inquired regarding the respondents' mental health training curriculum, which included structure, goals, strategies, evaluation, and outcome (Table S1). We asked the participants regarding their own experiences as well as documented information, such as guidelines or syllabi, if available. Subsequently, we conducted an exploratory descriptive analysis with individualized data.

2.2 | Ethics

The ethics committee of the JPCA approved this study (approval no. 2020-007). We informed the participants of the study purpose and obtained written consent. Participation was voluntary. We offered participants a gift card worth US\$50 as an honorarium for participating in the survey.

3 | RESULTS

A total of 13 participants completed the online survey. They were from Australia (3), Brazil (1), Hong Kong (1), the Philippines (1), Malaysia (1), Taiwan (1), the United Kingdom (3), and the United States (2). Of these, we excluded two (from Australia and the UK) who were not working for residency programs, and one (from Malaysia) due to incomplete responses. Consequently, we included data from 10 participants from seven countries and territories in the survey. Participants comprised five directors, including former directors, (one from the Philippines, Taiwan, and the UK, each, and two from the US) and five attending physicians.

3.1 | Goals in mental health training

In Hong Kong,²⁵ Taiwan, the UK,¹⁷ and the US,¹⁶ documented goals such as competency lists and curriculum guidelines for mental health training at the academic level have been set. Table 1 summarizes the training contents covered in their curriculums. In Brazil, each

TABLE 1 List of mental health competencies at the academic level^a

Areas	Description	Hong Kong ²⁵	Taiwan	UK ¹⁷	US ¹⁶
Primary care general skills					
Communication skills	Create a safe environment for patients to talk about mental health issues and gather and provide information as appropriate	o	o	o	o
Techniques to strengthen the doctor-patient relationship	Understand the importance of the doctor-patient relationship and be able to understand the different backgrounds of patients to strengthen the relationship	o	o	o	o
Respect for the patient's right to self-determination	Understand the importance of the patient's right to self-determination, be able to support the patient in making decisions, and share treatment plans according to their decision-making capacity	o		o	o
Use of resources for treatment	The ability to involve patients and their families and utilize community resources and information in treatment. They will also be able to liaise appropriately with other professionals	o		o	o
Doctor growth and self-care	Be able to reflect on their own practice and make improvements. Be able to care for themselves	o		o	o
Mental health general skills in primary care					
Attitudes toward mental health	Understand the importance of mental health and recognize biases toward mental health problems in themselves and others			o	o
Techniques for assessing mental health problems	Identify mental health problems with consideration of epidemiology and developmental aspects of individuals and families. Diagnose and evaluate mental health problems appropriately using tests and diagnostic criteria	o		o	o
Optimizing the management of mental illness	Recognize mental illness, initiate appropriate initial treatment, and follow up. Be able to refer and collaborate if necessary	o		o	o
Understanding of legislation relating to mental health	Understand the relevant legislation that may be involved in mental health	o		o	
Understanding and practicing the mind-body correlation	Be able to deal with the mental health of chronically ill patients and the physical complications of mentally ill patients. Be able to deal with MUS			o	o
Psychological education and preventive interventions	Provide the necessary psychoeducation to patients and their families. Provide preventive interventions (including occupational health, school health, and those in the medical institutions where they work) according to community needs	o		o	
Mental health specific skills in primary care					
Recognition, assessment and response to psychiatric emergencies	Recognize, assess, and initially respond to emergencies, such as exacerbation of mental illness, suicide ideation, abuse, and violence	o	o	o	o
Practicing cognitive, behavioral, and psychosocial interventions	Understand and be able to practice a range of cognitive, behavioral, and psychosocial interventions	o	o		o
Practicing drug therapy	Understand the indications and contraindications, dosage, side effects, and interactions of psychotropic drugs and be able to prescribe them as required	o			o
Addressing the mental health of specific groups	Understand the mental health characteristics of specific populations and be able to respond as required			o	
Understanding the typical symptoms and signs of mental illness	Be able to diagnose and initiate management for typical mental health problems. Be able to refer or collaborate with specialists if necessary	o	o	o	o

Note: Information on Taiwan was from a documented list of competencies, which was not published online.

^aAdopted and revised with permission from Kawada et al.,²⁰ who reviewed mental health curricula internationally to clarify the mental health competencies of family medicine residents.

residency program set individual goals. The respondent's program adopted goals from Spain. Australia had no specific goals set both at the academic and at the program level. The Philippines was developing a program with the WHO as a model.²⁶

Table 2 shows the topics that programs expected residents to learn to manage during the training. The most common were depression and anxiety disorders in all programs. Sleep disorders, neurocognitive disorders, substance-related disorders, psychotic disorders, bipolar disorders, and personality disorders were the next most common. Eating disorders and somatization disorders followed. Neurodevelopmental disorders and stress-related disorders, including posttraumatic stress disorder, were less common. The participants also mentioned psychiatric emergencies, including suicidal thoughts and abuse, as a condition that residents should learn to handle.

3.2 | Mental health training strategies

Table 3 shows requirement, duration, setting, method, and educators in the mental health training of each country and territory.

3.2.1 | Requirement and duration of mental health training

In Australia and the UK, psychiatric rotation was not mandatory but optional for residents. Rotation was mandatory in Brazil, the Philippines, Taiwan, and the US. The duration of rotation was 1–3 months in most cases. In some countries, such as Hong Kong and the UK, programs could extend it to a maximum of 6 months if residents wished. Brazil employed long-term, part-time longitudinal training (6 months of 5 h per week, which was equivalent to 1 month of full-time rotation).

3.2.2 | Mental health training setting

The most common training settings were outpatient clinics in family practice (Australia, Brazil, the UK, and the US). Psychiatric clinics followed (Brazil, Hong Kong, and the UK). Where psychiatry rotation was mandatory, residents received much of the training in inpatient and outpatient departments of psychiatric hospitals (Hong Kong, the Philippines, and Taiwan). Training was also provided at community mental health facilities in Australia, Hong Kong, and the US.

3.2.3 | Mental health training method

Outpatient consultation was the main method of mental health training. Only Hong Kong provided training through inpatient care. Common training methods were lectures, case discussions,

seminars, and off-the-job workshops. Role-playing, outpatient video review, and literature-based learning were less common.

3.2.4 | Educators in mental health training

Family physicians and psychiatrists were major providers of mental health training in primary care. This was followed by psychologists and only a few social workers, rehabilitation therapists, and community mental health professionals.

3.3 | Evaluation and assessment in training

Table 4 shows how and when each program conducted learner assessment and curriculum evaluation in mental health training. Learner assessment was conducted through written assessment exams in all countries and territories surveyed. OSCEs and case logs were popular; portfolios, video reviews, and oral examinations were less common. In addition, some countries used case reports and feedback letters from supervisors and coworkers as assessment methods of residents.

All surveyed countries and territories assessed the residents through board certification exams. Only some locations (Brazil, Taiwan, and the US) assessed residents after rotation. In addition, programs in the UK conducted assessments at the end of each residency year. Moreover, five of eight locations requested their residents to evaluate the training curriculum. Some locations had set feedback opportunities for supervising physicians in charge. However, none of the participants provided clear information about the effectiveness of their mental health training.

4 | DISCUSSION

We conducted the first survey to overview internationally mental health training in family medicine residency programs. These results suggest the path to follow for new mental health training in Japan and could help develop mental health training curricula in other countries.

4.1 | Availability of mental health training and goal setting in the training

All surveyed family medicine residency programs offered mental health training as psychiatric rotations or supervision by family physicians. It is well-recognized that family physicians providing mental health care in primary care are essential.²⁸ Therefore, training is required to address this need. A training period of 1–3 months was standard in this survey, which could be extended according to the needs of the program and the residents. However, including a new block rotation during the family medicine residency – which requires a wide range of topics to be covered and is already facing a shortage

TABLE 2 List of contents covered

Category ^a	Australia	Brazil	Hong Kong ²⁵	Taiwan	UK ¹⁷	US ¹⁶
Neurodevelopmental disorders				o	o	o
Schizophrenia spectrum and other psychotic disorders		o	o	o	o	
Bipolar and related disorders		o	o	o		o
Depressive disorders	o	o	o	o	o	o
Anxiety disorders	o	o	o	o	o	o
Obsessive-compulsive and related disorders			o			
Trauma- and stressor-related disorders			o	o	o	o
Dissociative disorders			o			
Somatic symptom and related disorders			o	o		o
Feeding and eating disorders	o			o		
Elimination disorders						
Sleep-Wake disorders		o	o	o		o
Sexual dysfunctions						
Gender dysphoria						
Disruptive, impulse-control, and conduct disorders						
Substance-related and addictive disorders		o	o	o		o
Neurocognitive disorders		o	o	o		
Personality disorders		o	o	o		o
Paraphilic disorders						
Other mental disorders						
Medication-induced movement disorders and other adverse effects of medication						
Other mental status						
Suicide	o		o	o	o	o
Violence/Abuse			o	o		o
Other			Organic Mental Disorder			Grief

Note: Australia and Brasil were based on the participants' personal information. Others were based on documented information.

^aCategories were adopted from APA.²⁷

of training time – may be challenging.²⁹ If block training, such as a one-month psychiatric rotation, is not practical, we propose longer periods of part-time training, such as weekly outpatient clinics, could be considered. There were curriculum guidelines and educational goals established at the national, academic, or program level, which clarified curriculum contents and competencies to gain. Given the current emphasis on outcome-based education,³⁰ it is essential to show the objectives of the training and the competencies that residents should gain. There was a wide range of educational goals between countries. It is necessary to set minimum requirements for competencies and diseases to be learned considering the current situation in Japan.³¹

4.2 | The structure and process of training: how, what, and who teaches

Surveyed programs, except that from the Philippines, provided mental health training for family medicine residents in the clinic or hospital outpatient department. This is appropriate given the role of family

physicians as primary care providers, as their training is consistent with their future clinical setting. Moreover, training was provided in community care facilities, such as addiction and rehabilitation centers. This is an important initiative given the global trend,²⁸ including in Japan,³² to provide mental health care in the community rather than in hospitals.

In Australia, the UK, and the US, family physicians provided mental health training for their residents, whereas in Asia, it was provided by psychiatrists. This trend may reflect how much family medicine has taken root in the community, and how confident family physicians were to manage mental health problems. Where mental health care by family physicians was well-established, they took responsibility for teaching. Given the current situation in Japan, only a limited number of residency programs can afford attending family physicians to independently provide mental health training. It is important to provide mental health training in collaboration with mental health specialists, such as psychiatrists, psychosomatic physicians, and psychologists.³³ Moreover, it is vital to provide faculty development programs for attending family physicians who serve as supervisors in the workplace. The GP Supervisors Australia,³⁴ which is an e-learning program, could serve as a model for faculty development program options. In terms

TABLE 3 Mental health training strategies

	Australia	Brazil	Hong Kong	Philippines	Taiwan	UK	US
Mandatory mental health rotation	No	Yes	Yes	Yes	Yes	No	Yes
Duration of rotation	NA	6 months (5 h/ week)	Within 6 months	1–3 months	Minimum 2 months (up to 4 months)	Elective for 3–6 months	NA
Training setting							
Family medicine clinic	o	o				o	o
Psychiatric clinic		o	▲				
Psychiatric outpatient			▲		o	▲	
Psychiatric inpatient	▲		▲	o	o	▲	
Community institution	▲				Mental health center		Addiction center
Training strategy							
Outpatient practice	o	o	o		o	o	o
Inpatient practice				o		▲	
Shadowing			o				o
Experiential learning		o					o
Lecture	o	o	o			o	o
Reading						o	o
Case discussion	o	o	o	o	o	o	
Role playing	o						
Consultation video review			o				o
Off-job seminar and workshop	o		o			▲	
Training staff							
Family physician	o	o	o			o	o
Psychiatrist		o	o	o	o	o	o
Other specialist doctor							o
Psychologist		o			o	o	o
Social worker					o		o
Rehabilitation therapist					o		
Community mental health worker						o	o

Note: All information was based on the participants' personal data and not documented data. ▲elective.

of collaboration with other professions, it would be useful to promote cooperation with psychologists, social workers, and other types of therapists, not only in mental health care but also in training.^{35,36,37} We believe that there is much to be learned from other professions in communication skills, cognitive-behavioral-psychosocial interventions, and the use of social resources. System-based support will be beneficial for improving both clinical practice and training. In the UK, for example, family physicians have easy access to online professional consultations with community psychiatrists who also regularly visit clinics for in person consultations. This kind of community network is one of the strategies that were developed to facilitate collaborations with mental health specialists. It also provides opportunities for family medicine residents and attending physicians to receive timely feedback.

4.3 | Learner assessment and curriculum evaluation

All surveyed programs used written exams or OSCEs in board certification exams for learner summative assessment. For communication skills, immediate formative assessment and feedback in the workplace are more effective;³⁸ thus, assessment tools need to be developed. In many countries and territories, residents evaluated their training programs. However, we need to note that there was no clear evidence addressing the effectiveness of the surveyed mental health training. Although there are studies that have evaluated interventions for mental health training in primary care,²⁹ the interventions were short-term courses on specific topics, not whole residency programs. We

TABLE 4 Assessment of residents and evaluation of curricula

	Australia	Brazil	Hong Kong	Philippines	Taiwan	UK	US
Evaluation method							
Written exam	o	o	o	o	o	o	o
OSCE	o		o		o	o	
Case log				o		o	o
Portfolio				o	o	o	
Consultation video review						o	o
Oral exam	o			o			
Other				Case study report	Evaluation and feedback from supervisors	Workplace evaluation	Participation in lectures
Timing of evaluation							
After rotation		o			o		o
Board certification exam	o	o	o	o	o	o	o
Other						Annually	
Evaluation of the program							
From residents	o		o		o	o	o
From supervisors	o					o	

Note: All information was based on the participants' personal data and not documented data.

can introduce those methods for training components, however, although the evidence is insufficient, we need to initially adopt common training curricula. Thus, it is vital in the development of new curricula in Japan to have a system in place for feedback and improvements.^{39,40}

4.4 | Limitations and future research

This survey had a limited number of participants, and we need to consider the contextual dependence and selection bias. Furthermore, there are most likely variations within each country and our data is only a sample from each program. Therefore, data used in this study may not be a comprehensive and accurate representation of the actual information. In addition, mental health cannot be separated from the cultural and social contexts. We must pay careful attention to apply the results to Japan. In implementing training, a thorough understanding of the current situation in Japan and integrating these factors are essential. Another limitation is that the effectiveness of the surveyed mental health trainings is still unclear. The best measures of educational outcome are changes in actual clinical practice, especially patient-oriented outcomes, but this area requires further research. Therefore, we need to promote research which targets multiple outcome levels, including physician, patient, and population health outcomes.²⁹

Furthermore, employing the method that we used in this study is expected to be helpful for future studies to collect more data

from other countries. The findings of which are hoped to be beneficial in the development and evaluation of mental health training curriculum.

5 | CONCLUSION

The JPCA Mental Health Committee surveyed the current status of mental health training curricula in family medicine residency internationally. The results revealed that many countries have set goals, competency lists, and curriculum guidelines for mental health at the academic level. However, there is no uniformity regarding whether mental health training is mandatory, the main training setting, and main training providers. Therefore, tailor-made training is required for individual countries and contexts. These results could be used as a reference to develop a training curriculum considering the status of mental health care, training, and resources in Japan.

AUTHOR CONTRIBUTIONS

SK, JM, HW, MK, and KI interviewed participants and analyzed text data. SK wrote the manuscript. TO assisted in writing the manuscript. All authors read and approved the final manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interests for this article.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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